STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	R 04/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHOE MEDICAL CENTER-SKILLED NURSING	1835 ODDIE BLVD. SPARKS, NV 89431

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{F 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a follow-up survey to the annual Medicare Re-certification Survey on 2/1/06. The follow-up survey was conducted on 04/03/06. The sample size was 14. Two complaints were investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. Complaint #NV00011209 was a self-reported incident of a resident grabbing another resident by the leg and hitting it on the wheelchair foot rest. The incident did occur with no regulatory deficiencies cited. Complaint #NV00011200 was a self-reported incident of a resident attempted elopement. The incident did occur with no regulatory deficiencies cited. Your facility was found not to be in compliance and the following regulatory deficiencies were cited:	{F 000}		
{F 309} SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		

RECEIVED 4/14/06
APR 11 2006
BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ellen Kelly RN, MPH, RD	Administrator	4/10/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 309}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that physician orders and facility policy for bowel movement management were followed for 1 of 14 residents sampled. (Resident #14). Findings include: Review of the facility policy identified as Bowel Movement Monitoring revealed that on 3/15/06 the policy was revised. Item #9 included the statements: "if no result from the suppository within 4 (four) hours the nurse would document on the med-sheet result section, and that the physician would be notified if all the above measures (laxative and suppository) were not effective." Item #12 read that if the possibility of chronic constipation is suspected by the licensed nurse, the nurse is to notify the attending physician and the Director of Nursing in order to access appropriate clinical measures to support the resident." Resident #14: Record review revealed that on 3/9/06, a physician's order was written to discontinue the facility's standard bowel management orders, as the resident was under hospice care. There was no further documentation in the orders as to what bowel regime the resident was to be on, or if there were hospice standing orders for bowel management. On 3/15/06, the record reflected that a facility standing order was added. This order was	{F 309}		

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{F 309}	Continued From page 2 identified as "House Bowel Program Orders." The orders read: "Please discontinue previous house bowel orders/clarification of house bowel orders. 1. MOM (milk of magnesia) 30 ccs by mouth/gastrostomy tube/nasogastric tube, every second day as necessary for no bowel movement in the last two days. 2. If no results from MOM within 24 hours, give Dulcolax suppository, 5 mg for no bowel movement. This dosage was changed to 10 mg. 3. If no results from Dulcolax suppository within 24 hours, notify physician." This order was signed by the physician. An interview with a Risk Manager on 4/3/06 revealed that the two day time period for lack of BM and need for intervention was not two calendar days but six shifts, specifically the eight hour shifts that the CNAs worked. Review of the intake/output, bowel record revealed that the CNA staff documented an absence of bowel movements for Resident #14 from: 3/17-3/19/06 over 7 (seven) shifts, 3/19-3/22/06 over 10 (ten) shifts, 3/23-3/26/06 over 11 (eleven) shifts, and 3/27-3/29/06 over 8 (eight) shifts. Further documentation by the CNA's on this tracking record revealed that on 3/20-21/06, MOM was given during the 11:00 PM - 7:00 AM and again on the 3:00 PM - 11:00 PM shift. An entry on 3/22/06 (7:00 AM - 3:00 PM shift) read "no BM, 3rd day, nurse notified." An entry on 3/22-23/06 (11:00 PM - 7:00 AM shift) read "a suppository given with a subsequent medium	{F 309}		

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{F 309}	Continued From page 3 sized bowel movement." On 3/25/06 (3:00 PM - 11:00 PM shift), no BM for two days was documented. An entry for the 3:00 PM - 11:00 PM shift of 3/26/06 revealed that "3rd day no BM Nurse notified." On 3/26-27/06 (11:00 PM - 7:00 AM shift), it was indicated that the resident had a large BM. The entry on 3/29-30/06 (11:00 PM - 7:00 AM shift) indicated that a suppository was given after 8 shifts of no BMs. Review of the nurses notes revealed an entry on 3/25/06 that the resident had no bowel movement for two days...night shift to give MOM per BM protocol. A 3/26/06 entry indicated that the resident had a BM. A 4/2/06 entry read that resident "had no BM after supplied MOM because of no eating." Review of the MAR (Medication Administration Record) revealed that there was no documentation of MOM having been administered to the resident between the period of 3/15/06 - 3/31/06. There were two orders dated 3/15/06 which read, "if no results from MOM within 24 hours, give Dulcolax suppository as necessary. One order indicated a 5 mg dose, the second order indicated a 10 mg dose. Documentation on the front side of the MAR indicated that a 10 mg Dulcolax was administered once on 3/19/06, twice on 3/22/06 and once on 3/29/06. Documentation on the back side of the MAR indicated that a Dulcolax suppository was only administered on 3/19/06. The reason documented was that "0 (no) BM (days) 0 (no) results from MOM." Random interviews on 4/3/06, with an RN (registered nurse) staff of the facility and a hospice RN revealed and confirmed that there	{F 309}		

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{F 309}	Continued From page 4 was no documentation in the record that the nursing staff communicated between disciplines or that the physician was notified to report the resident's lack of bowel movements, the ineffectiveness of interventions, or reevaluation of the orders related to the resident's medical conditions. It was also confirmed that there was no evidence that the facility's policy regarding bowel management had been followed. An interview with the DON revealed that although the facility was auditing records for compliance, the events on this record for Resident #14 had not been audited.	{F 309}		
{F 492} SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and interview, it was determined that the facility failed to ensure that a gastrostomy tube was cared for according to professional standards of practice for 1 of 14 residents. (Resident #11) Findings include: Resident #11: The resident was admitted to the facility on 8/2/85 with diagnoses including multiple sclerosis, dysphagia, anemia, and constipation. On 3/23/06 it was documented that a certified	{F 492}		

4/6/06 bc

F 309

IDENTIFICATION:	COMPLETION DATE:
1. Resident #14 is on hospice services. All hospice residents currently in-house were reviewed by the hospice provider, Circle of Life, and facility nursing management staff.	04/03/2006
2. A complete audit of every resident in the facility as of 04/04/2006 was completed. Time period of 04/04/2006 to 04/06/2006 was monitored for procedural compliance. Each case was assessed for compliance with: • CNA Bowel Log documentation • CNA to nurse notification • Administration of bowel protocol medications • Accuracy of medication administration record entries.	04/07/2006

CORRECTIVE ACTION:	COMPLETION DATE:
1. Hospice policy was revised to follow the skilled nursing bowel protocol.	04/03/2006
2. Case of resident #14 was retrospectively reviewed by Nursing Manager and Clinical Risk Manager.	04/03/2006
3. Rounds were conducted across day and evening licensed nursing shifts to verbally assess staff comprehension of policy parameters.	04/07/2006

SYSTEMIC ACTION:	COMPLETION DATE:
1. Any hospice resident unable to follow the facility's bowel protocol shall be referred to the hospice physician. Any changes in bowel protocol will be documented in the medical record of the individual. Facility Nursing Management and Administrator shall be verbally notified by the hospice provider in any case where this process must be implemented.	04/07/2006
2. Hospice provider shall educate their licensed nursing staff on this procedure change and provide written verification to the facility.	04/07/2006
3. A special case needs provision was added to the facility's policy. A physician's order is required to invoke the special case status. CNA monitoring remains unchanged with this provision.	04/07/2006
4. Facility has engaged a nursing consultant group to review facility's nursing operations and documentation processes in regards to F309 Quality of Care. Consultants shall draft improvement recommendations for review by the Health System's Chief Nursing Officer.	04/11/2006 - 04/13/2006
5. Random sample audits will be conducted across the facility to assess continued policy compliance post the implementation of corrective and systemic actions.	04/14/2006

6. Shift-to-shift reporting between licensed nursing staff will include bowel status information. Reporting sessions will be periodically audited by nursing manager for compliance.	04/11/2006 and ongoing
7. Hospice Administrator has been instructed to have her nurses utilize the unit's 24-hour report book for endorsing additional information to other facility nursing shifts. Hospice staff will be educated on the use of this report book by the hospice administration.	04/08/2006 04/12/2006

QUALITY MONITORING:	COMPLETION DATE:
Compliance with facility's bowel protocol and trends in resident bowel care shall be reported to the facility's Quality Improvement Committee on a quarterly basis.	First audit 04/08/2006 First quarterly audit 07/06/2006

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{F 492}	Continued From page 5 nursing assistant (CNA) reported to the licensed practical nurse (LPN) that the resident's gastrostomy tube (G-tube) was dislodged. The LPN initiated a procedure of inserting a Foley catheter into the stoma and inflating the bulb. The LPN checked for residual and flushed the catheter with 30 cc's of water. The nurse then called the physician and asked for an order to transport the resident to the emergency room to have the G-tube reinserted. The order was received and the resident was transferred to the emergency room for G-tube replacement. On 3/24/06 at 2:30 AM a CNA reported to an LPN that the resident's G tube was again dislodged. The LPN on duty initiated the same catheter procedure as before, but did not flush the catheter with water and taped the catheter to the resident's abdomen. Resident #11 was transferred to the emergency room for G-tube replacement. The facility's policy read: "In an event that a Gastrostomy tube/PEG tube gets pulled, a licensed nurse may re-insert a Foley provided that a 6-week period has been established since insertion date. The main purpose is to safely maintain patency of the stoma. Arrangements are to be made to send the resident to WMCER for replacement of the G-tube. Any other G-tube/PEG tubes less than 6-weeks old needs to go WMCER for re-insertion. An interview with the Director of Nursing and the Administrator revealed that the policy was revised in March of 2006 and did not include flushing anything into the catheter. Contact with the Nevada Board of Nursing	{F 492}		

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{F 492}	Continued From page 6 revealed that the nurse practice act does not allow an LPN to perform such a skilled procedure. The procedure must be performed by a registered nurse (RN) with additional training and demonstration of competency of the procedure.	{F 492}		

F 492

IDENTIFICATION:	COMPLETION DATE
1. All tubes throughout the facility were rechecked for any other instance of device insertion at the skilled facility.	04/03/2006
2. Sessions were conducted for licensed nursing staff to review the facility policy on G-tube management. Question and answer session was held to review LPN versus RN scope of practice and to insure policy comprehension.	04/03/2006

CORRECTIVE ACTION:	COMPLETION DATE:
1. Record of resident #11 was reviewed by nursing management.	04/03/2006
2. Policy on gastric tube insertion was revised to incorporate clear delineation of required practice. Policy enclosed.	04/03/2006
3. All licensed nursing staff is being met by nursing management as they come onto their shift. No licensed nurse is assuming as assignment until they have read the revised policy and signed the acknowledgement. Actions taken over 04/03/2006 to 04/06/2006 to address all rotating staff.	04/06/2006

SYSTEMIC ACTION:	COMPLETION DATE:
1. Facility will not be moving forward with a core of compentencied RNs to perform reinsertion. Statement provided to survey team leader on site.	04/03/2006
2. All nursing policies are being reviewed to insure any related policies	04/04/2006

properly reflect this change in facility practice.

QUALITY MONITORING:	COMPLETION DATE:
1. All residents currently on enteral nutritional support were retrospectively reviewed by an interdisciplinary team for compliance with facility policy, tube-site status, and care plan updates as applicable.	04/04/2006
2. Any future resident cases where a gastrostomy tube is dislodged shall be reviewed by nursing management for compliance with facility policy and Nevada State Board of Nurse Practice Act.	04/03/2006
3. Facility's Quality Improvement Committee shall receive quarterly updates on compliance with this procedure and any other quality trends noted from individual case reviews.	First audit 04/10/2006 First quarterly audit 07/06/2006

Washoe Medical Center

Skilled Nursing

4/3/06

Reviewed F Tag 309 and F Tag 492 with facility's Medical Director, Dr. Denver Miller. Practices of other skilled nursing facilities in relation to G-tube insertion were checked. Literature review by Medical Director. Also reviewed Nevada State Board of Nursing – Nursing Practice Decisions. Discussed with Washoe Medical Center, Clinical Risk Manager, Sadie Tate Crowder, RN. Determination to continue to send out cases requiring G-tube replacement and not to proceed with competency preparation of a core group of on site nurses.

Ellen Kelly NHA
Signature

4/3/06
Date